MDR Tracking Number: M5-05-0430-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 9-30-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that office visits, manual therapy techniques, therapeutic activities, ultrasound, chiropractic manipulation and neuromuscular reeducation from 12-4-03 through 5-28-04 were not medically necessary. Therefore, the requestor is not entitled to a reimbursement of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-30-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT code 99080-73 on date of service 11-17-03 was denied as "D" – "The provider has billed for the exact services on a previous bill." Since neither party submitted the original EOB, Medical Dispute Resolution cannot determine the correct denial reason. **Recommend no reimbursement.**

CPT code 99211 on dates of service 11-18-03, 11-19-03, 11-21-03, 11-24-03, 11-25-03, 11-26-05, 12-01-03, 12-02-03, 12-03-03, 12-04-03, 12-05-03, 12-09-03, 12-10-03, 12-12-03, 12-15-03, 12-19-03, 12-22-03, 12-29-03, 12-31-03, 1-02-04, 1-05-04, 1-9-04, 1-12-04, 1-14-04, 2-18-04, 2-20-04, 2-25-04, 4-19-04, 4-21-04, 4-23-04, 4-26-04, 5-5-04, 5-7-04, 5-10-04, 5-12-04, 5-14-04 and 5-21-04 was

denied as "N" – "Documentation submitted does not support the services billed." Requestor did not submit relevant documentation to support level of service per 133.307(g)(3)(B). Per Rule 133.307 (g) (3)(B) the additional documentation shall include a copy of any pertinent medical records or other documents relevant to the fee dispute. **Reimbursement is not recommended.**

CPT code 97140 on date of service 12-19-03 (2 units) was denied as "F" – "Reimbursement was reduced or denied after reconsideration of treatment/service billed. The HCFA shows that 2 units were billed. The MAR is \$32.55. The carrier has reimbursed for 1 unit and the second unit was denied as "U". **No additional reimbursement recommended.**

CPT code 97110 on date of service 12-15-03 was denied as "F" -"Reimbursement was reduced or denied after reconsideration of treatment/service billed. Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended.

This Findings and Decision is hereby issued this 18th day of March, 2005.

Donna Auby Medical Dispute Resolution Officer Medical Review Division

Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive Austin, Texas 78738 **Phone:** 512-402-1400 **FAX:** 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 3/16/05

TWCC Case Number:	
MDR Tracking Number:	M5-05-0430-01
Name of Patient:	
Name of URA/Payer:	Rudolph A. Theobald, DC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Rudolph A. Theobald, DC

December 29, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating

physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

Available information suggests that this patient reports experiencing a right shoulder injury initiated ____ following a work related accident. Available billing information suggests that this patient was under the care of Rudolph Theobald, DC, for several months of chiropractic manipulation and physical therapy. The patient also appears to have received medication and joint injections. There are no chiropractic reports or chart notes submitted for review. There is an orthopedic report submitted 8/16/04 by Joe Daniels, DO, suggesting a diagnosis of anterior right shoulder impingement with biceps tendonitis. Daniels indicates that there has been no measurable improvement with conservative care and the patient remains acutely symptomatic. It appears that right shoulder arthroscopy and acromioplasty is performed 10/26/04. Orders for post surgical physical therapy include aquatic therapy, active therapy, and neuromuscular reeducation for 4-5 weeks. No notes or reports from this post-operative therapy are provided for review.

REQUESTED SERVICE(S)

Determine medical necessity for manual therapy techniques (97140), therapeutic activities (97110), ultrasound (97035), office visits (99211, 99213, 99215), chiropractic manipulation (98940) and neuromuscular reeducation (97112) for dates in dispute 12/4/03 through 6/4/04.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Medical necessity for chiropractic treatments and services (12/4/03 through 5/28/04) are not supported by available documentation. Ongoing therapeutic modalities of this nature, other than those

outlined in orthopedic reports for post-op care, suggest little potential for further restoration of function or resolution of symptoms. No measurable improvement is reported. With appropriate documentation submitted for post operative therapy, some of these services may be considered as reasonable and customary. However, without supporting clinical documentation of this nature, none of these submitted services could be considered as medically necessary.

REFERENCES:

- 1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.
- 2. Brotzman B, Wilk K, "Clinical Orthopedic Rehabilitation," 2nd Ed., ISBN 0-323-01186-1, Mosby Press, 2003, pp. 236-238.
- 3. Bigos S., et. al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.
- 4. Harris GR, Susman JL: "Managing musculoskeletal complaints with rehabilitation therapy" <u>Journal of Family Practice</u>, Dec, 2002.
- 5. Nicholson, G.G. "Rehabilitation of Common Shoulder Injuries." Clin in Sports Med. 1989 8:(4) pg. 633-655.
- 6. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.